PHYSICIAN-PATIENT RELATIONSHIP
FINDINGS AND RECOMMENDATIONS

I. FINDINGS

The physician-patient relationship is fundamental to health care delivery. Cardinal Bernardin, in a statement given to the American Medical Association House of Delegates in 1995, shortly before his death from pancreatic cancer, described the physician-patient relationship as a covenant. He stated:

> The moral center of the doctor-patient relationship is the very essence of being a doctor. It also defines the outlines of the covenant that exists between physicians and their patients, their profession, and their society. The covenant is a promise that the profession makes – a solemn promise – that it is and will remain true to its moral center. In individual terms, the covenant is the basis on which patients trust their doctors. In social terms, the covenant is the grounds for the public's continued respect and reliance on the profession of medicine.[1]

The physician-patient relationship is multi-faceted, making an understanding of the impact of managed care difficult. In addition, physicians are not the only providers who may have a significant relationship with a patient. The covenant described above as well as the other issues discussed in this paper are not exhaustive and in general may be applied to all appropriately-licensed health professionals, operating within their scope of practice.

Although the effects are inherently difficult to study, beneficial relationships between physician and patient have been shown to decrease and/or shorten hospitalizations, lower utilization of resources, enhance compliance, and improve satisfaction among patients and physicians.[2,3,5] There is also some evidence about the impact of external factors on the physician-patient relationship: that the availability of a choice of health plans increases patients' satisfaction with their physicians.[4]

Views of physicians and patients, as well as physician-patient relationships have evolved over time. Recently, however, the nature of the physician-patient relationship has changed. The increased presence of third-party payers in the health care system over the last 30 years has eroded

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[1] Cardinal Bernardin J, "Renewing the Covenant with Patients and Society", Address to AMA House of Delegates, Washington, DC, December 5, 1995.

[2] Weiss L and Blustein J, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on Costs and Use of Health Care by Older Americans", *American Journal of Public Health*, 86:12, December 1996, 1742-1747.

[3] Brody DS, et al., "Patient Perception of Involvement in Medicare Care: Relationship to Illness Attitudes and Outcomes", *Journal of General Internal Medicine*, 4, November/December, 1989, 506-511. Also see Greenfield S, et al., "Expanding Patient Involvement in Care: Effects on Patient Outcomes", *Annals of Internal Medicine*, 102, 1985, 520-528 and Greenfield S, et al., "Patients' Participation in Medical Care: Effects on Blood Sugar Control and Quality of Life in Diabetes", *Journal of General Internal Medicine*, 3, Sept/Oct, 1988, 448-457.

[4] Davis K, "Employees Lack Options Among Health Plans", The Commonwealth Fund, August 1997.

the trust between physician and patient.[5] Managed care has added sources of doubt. Important factors that appear to have contributed to this decline in trust include issues related to: (a) continuity with physicians, (b) the coordinating role of primary care physician and utilization review, (c) informing patients of all options, (d) financial incentives, (e) physician availability, and (f) quality improvement programs and patient confidentiality.

A. Continuity with Physician

A continuous relationship with a physician provides familiarity with patient medical histories. As a result, doctors can react quickly in emergencies, make knowledgeable decisions, and handle many situations on the telephone. In addition, studies have shown that patients staying with the same physician for long periods are less likely to be hospitalized, more likely to have lower costs, and to be more satisfied.[6] Many HMOs attempt to formalize this relationship through the designation of primary care physicians (PCPs). Several features of HMOs and the health insurance market, however, tend to make continuity of care difficult to maintain. These include closed HMO panels if the enrollee or provider leaves the plan, termination of physician contracts, changes in coverage by employers, and lack of choice and information.

B. Coordinating Role of Primary Care Physician and Utilization Review

An additional factor affecting the physician-patient relationship is the coordinating role of primary care physician and utilization review. The model is based on the United Kingdom's general practitioner with the intent of improving quality and reducing costs by coordinating care through one provider. Although studies have shown that as many as 30% of procedures are medically unnecessary,[7] denying access to care–whether necessary or not–strains the physician-patient relationship.[8] Conflict may result when HMOs, medical groups/IPA, or physicians deny referrals to specialists,[9,10] referrals to procedures,[11] and referrals to care outside the HMO network.

C. Informing Patients of All Options

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[5] Gray B, "Trust and Trustworthy Care in The Managed Care In The Managed Care Era," *Health Affairs*, 16:1, January/February 1997, 34-49; and Gray B, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*, Cambridge: Harvard University Press, 1991.

[6] Weiss LJ, Blustein J, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans", *American Journal of Public Health*, Volume 86, pp. 1742-7, 1996; and Blumenthal, D, et al;, "The Efficacy of Primary Care for Vulnerable and Other Population Groups," *Health Services Research*, 30, 1995, 253-273.

[7] Sui AL, et al., "Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans," *The New England Journal of Medicine*, November 13, 1986, 1259-1266; Chassin MR, et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures," *Journal of the American Medical Assocation*, November 13, 1987, 2533-2537; and Winslow DM, et al., "The Appropriateness of Performing Coronary Artery Bypass Surgery", *Jounral of the American Medical Association*, July 22, 1988, 505-509.

[8] Blumenthal, D, "Effects of Market Reforms on Doctors and Their Patients," *Health Affairs*, Summer 1996, 170-184.

[9] Op-Cit., Blumenthal, D, 1996; and Ayanian JZ, et al., "Knowledge and Practices of Generalist and Specialist Physicians Regarding Drug Therapy for Acute Myocardial Infarction," *The New England Journal of Medicine*, 318:20, 1988, 1310-1314.

[10] Center for Studying Health System Change and Mathematica Policy Research Inc., nationwide survey of physicians.

[11] Mechanic D, Schlesinger M, "The Impact of Managed Care on Patient's Trust in Medical Care and Their Physicians," *JAMA*, 275:21, June 5, 1996, 1693-97.

Physicians should help patients to make informed decisions based on the advantages and disadvantages of each option and the patient's personal preferences. Although "gag clauses" have been banned in California and management guidelines are generally intended as recommendations, there is still some fear that improper discussion or behavior may result in contract termination by the health care plan or medical group/IPA.[12]

D. Financial Incentives

While principally professional ethics and desire for the esteem of their peers motivate physicians, they also face financial incentives. All compensation arrangements contain incentives which may have positive and negative effects. An important issue is whether or not patients have access to information about how their medical care is paid for (see Provider Financial Incentives paper). Several forms of compensation arrangements in managed care, including capitation and risk pools, shift financial risk for caring for patients to providers. Although these structures may create incentives for physicians to limit unnecessary care and reduce costs, they also have the potential to reward physicians for denying medically appropriate care. This form of compensation may also reduce patient satisfaction and erode trust between patients and physicians.[13]

E. Physician Availability

When people are sick, they want to see their physician and expect their physician to be available; they want appointments to be available within a reasonable time frame, and to be long enough for evaluation and treatment.[14] Adequate physician availability can prevent miscommunication, non-communication, disputes, and grievances. Current law requires Knox-Keene regulated health plans to restrict physician panels to 2,000 patients per PCP.[15] Availability, however, may depend on the skill of the physician and the health of the patient panel. To reduce costs, managed care organizations often replace physicians with less expensive practitioners such as advanced practice nurses or physician assistants.[16] Less expensive practitioners offer increased access at lower costs and may demonstrate better communication skills than physicians. Physician visits have both medical and emotional impact. Shorter visits that may be medically acceptable can still be a source of patient dissatisfaction.

F. Quality Improvement Programs and Patient Confidentiality

Purchasers have largely driven quality measurement and improvement efforts. While not universal and still under development, these quality measurement efforts offer feedback to providers to improve and information to purchasers and consumers to judge quality and service. Quality improvement programs have resulted in increased paperwork which requires the investment of significant time and effort, the benefits of which may not be readily apparent to those required to provide the data. Several experts have noted that trust in physicians' decisions is increasingly supplemented by evidence such as that provided by disclosure of quality improvement and

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[12] US General Accounting Office, "Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physician Concerns Remain" (GAO/HEHS-97-175), August 1997.
[13] Op-Cit., Blumenthal, D, 1996.
[14] California Public Employees' Retirement System, *1995 Open Enrollment Exit Survey: Final Report for Basic Health Plans*, Sacramento, CA, April 16, 1996.
[15] Item H(i) Primary Care Providers in Commissioner's Rule 1300.51(d) in Title 10, California Code of Regulations.
[16] Felt-Lisk S, "How HMOs Structure Primary Care Delivery," *Managed Care Quarterly*, 1996; 4(4), 96-105.

measurement results.[17] However, the current system lacks a systematic mechanism for assessing and informing patients about the experience and competence of their health care delivery system and personal physician.[18] Quality improvement and similar efforts as well as the delivery and payment of care require confidential patient information, the use of which must be balanced with respect for patient privacy.

II. RECOMMENDATIONS

A guiding principal for the recommendations of this Task Force and health care system change in general should be an evaluation of the effect of the proposed change on the covenant of the physician-patient relationship described by Cardinal Bernardin.

[NOTE: Some members requested that we re-state in full any recommendation referenced herein to another paper, upon adoption by the Task Force. Please note that this paper refers to 22 recommendations made elsewhere.]

A. Continuity with Physicians

In addition to recommendations in the Consumer Information, Communication and Involvement paper regarding disclosure and presentation of information about provider availability, the following recommendations could further address continuity issues:

1. (a) The Governor and Legislature should authorize the state's agency for managed care regulation to require health plans and medical groups/IPAs to write contractual arrangements that enable consumers who are undergoing a course of treatment for a chronic, acute, or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan or medical group/IPA for other than cause to be able (at the patient's option) to continue seeing their current specialty providers until the course of treatment (or postpartum care) is completed up to a maximum of 90 days or until the patient's condition is such that the patient may be safely transitioned to a new provider.

   (b) Providers who continue to treat such patients must accept the plan's rates as payment in full, provide all necessary information to the plan for quality assurance purposes, and promptly transfer all medical records with patient authorization during the transition period.

B. Coordinating Role of Primary Care Physician and Utilization Review

In addition to recommendations in the Medical Necessity paper regarding modification of prior authorization procedures and in the Dispute Resolution paper regarding disclosure and procedures related to referral denials, the following recommendations could further address coordination issues:

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[17] Op Cit., Gray B, "Trust and Trustworthy Care" 1997.

[18] Ezekiel EJ and Dubler NN, "Preserving the Physician-Patient Relationship in the Era of Managed Care," *JAMA*, 273:4, January 25, 1995, 323-329.

2. The Governor and the Legislature should act to require health plans to establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive an extended, prolonged, or permanent referral to a specialist if the primary care provider determines in consultation with the specialist, if any, and the plan medical director that an enrollee needs continuing care from a specialist. Such referrals should be conducted in a manner that maintains coordination of services (e.g., updating the PCP, sharing of medical records, agreeing on shared treatment plans, and agreeing on the respective roles of each practitioner).

C. Informing Patients of All Options

Recommendations related to informing patients of all options are included in the Standardization paper regarding disclosure of information in Evidence of Coverage and other documents and in the Consumer Information, Communication, and Involvement paper regarding disclosure about medical groups' networks.

D. Financial Incentives

Recommendations related to financial incentives are included in the Task Force paper on Provider Financial Incentives.

E. Physician Availability

In addition to recommendations in the Risk Avoidance paper regarding risk adjustment, the following recommendations could further address physician availability issues:

3. If a patient is specifically assigned or chooses a primary care provider and the provider's medical group/IPA or health plan directs that patient to another physician, advanced practice nurse or physician assistant, the patient should be informed verbally and consent.

F. Quality Improvement Programs and Patient Confidentiality

In addition to recommendations in the Task Force paper on Consumer Information, Communication and Involvement regarding continuing efforts to make public and private quality studies readily understandable and available to consumers, and in the Streamlining paper regarding consolidation of quality auditing, the following recommendations could further address quality improvement programs:

4. Information on quality of care process and outcomes should be collected and disseminated as recommended in the Task Force paper on New Quality Information Development. As information becomes available, physicians should include all relevant information at every level of care in the informed consent process. To the extent information is known, accurate, and reliable, a physician and hospital should make available upon request all relevant information regarding their experience and or qualifications regarding a course of care patients are considering.

5. With very few exceptions (such as medical or health care research where anonymous records will not suffice, investigation of health care fraud, and public health reporting), individually

identifiable health care information can be used without written consent for health purposes only, including the provision of health care, payment for services, peer review, health promotion, disease management, and quality assurance. When disclosure is required, no greater amount of information should be disclosed than is necessary to achieve the specific purpose of the disclosure. Otherwise, information should not be released unless authorized by patient consent or by law.